

Continuity of Care Work group
Clinical subgroup

Report-Out Session

Minutes 9/16/13

Subgroup Members:

Present	Not present
John Boronow (cochair)	Joel Kanter
Anne Hanson (cochair)	Ann Geddes
Lori Doyle	David Maina
Dan Martin	Jan Caughlin
Susan Stromberg	Jennifer Lowther
Louise Treherne	Linda Raines
Ken Wireman	Charles Gross
	Bob Pitcher

Other Participants:

Lois Fisher	Evelyn Burton	Derrick Richardson
Vanessa Purnell	Mike Finkle	Eileen Hansen
Kait Roe	Tim Santoni	Ryan Shannahan
Jamie Miller	Stacy Rudin	Laura Cain
Elaine Carroll	Chris Scardapane	Zereana Jess-Huff
Steve Daviss	Jodie Chilson	Jane Plapinger
Edgar Wiggins	Diana Seybolt	Raymond Crowell
Shantelle Stroman	Haward Sigler	Teresa Bennett
Clarissa Netter	Steve Johnson	Hardy Bennett
Anita Everett	Katie Wunderlich	Scott Greene
Ed Kelley	Lisa Hadley	Janet Edelman
Caroline Bolas		

DHMH Staff: Erik Roskes

The meeting began at 1300.

John Boronow, Chair, presented a detailed power point and discussion that encapsulated the discussions during the Clinical Subgroup's five meetings, held on five consecutive Tuesdays between August 13 and September 10. Of specific note are the following:

- Several global and specific recommendations were made by the Clinical Subgroup, about which there was general consensus
- On some specific issues, and most notably on the potential role of outpatient commitment, there was no consensus reached

- While the focus as directed by the Continuity of Care Advisory Group was the state's population of adults with severe mental illness, of necessity there were points and issues discussed that related to children, the elderly and other subpopulations.
- The Subgroup did not receive data in time to be considered or included in the presentation. While the Subgroup members have vast experience in the topics that were discussed, the lack of data on some questions did hinder the Subgroup's ability to make firm recommendations. Clearly, accurate, reliable, and timely data will be required if we are to make informed decisions about how to modify the clinical system of care for people with serious mental illness.

Dr. Boronow's powerpoint file is appended to these minutes for detailed review.

Main points:

- Global inadequacy of outpatient resources, including both inadequate capacity and in many places inadequate array of services/trained providers
- Specific inadequacies in a variety of areas including:
 - Crisis care
 - Services for TAY/Emerging Adults
 - Silos: MH/DD/ID/TBI/somatic
 - Silos: MH/Substance abuse
 - Services for people without insight (anosagnosia)
 - Need for trauma informed services
 - Elderly with SMI
 - Geographic limitations (especially rural)
 - Issues related to insurance coverage
 - Transportation
 - Childcare
 - Homelessness

Specific recommendations on which there was good consensus by the Subgroup:

- **Incentivize providers** via a "pay for performance" mechanism, such that good outcomes are rewarded
- Expand/revise/systematize **crisis services** statewide
- Enhance services for **TAY/young adults/first episode patients**
- Develop novel funding for people with **SMI/somatic needs** (medical home is a promising model)
- Enhance/systematize **"dual diagnosis"** services for SMI/addiction statewide
- Enhance/systematize **jail/prison reentry** statewide
- Integrate care and funding for people with **MH/DD/ID/TBI needs**
- Enhance/systematize **trauma-informed** approaches to care statewide
- Improve **transition into eldercare** services for aging SMI patients
- **Reduce regional disparities** around the state
- Consider **workforce expansion** incentives and approaches, including loan forgiveness programs for populations who are underserved (regardless of whether the specific region is underserved taken as a whole)
- **Expand residential capacity**, including supported residential services, for people with SMI

As noted above, several recommendations were considered regarding engagement of people with little insight or motivation to engage in services. The Subgroup spent much time discussing the pros and cons of outpatient commitment, potential changes to the psychiatric advance directive approach, changes to the clinical review panel statute, and changes to civil (inpatient) commitment laws, without reaching consensus on any of these issues. Those discussions are summarized in prior Subgroup minutes, and the Subgroup has no specific recommendations in regard to these controversial topics. Where the Subgroup generally did agree was this:

Whether through outpatient commitment or through other engagement mechanisms, **there is clearly a need for enhanced intensive outpatient approaches**, including intensive forms of case management and ACT programs, along with the enhanced supportive housing approaches and improved dual diagnosis approaches discussed above.

During the response section of the meeting, a number of themes became clear:

- There was overall agreement that the current outpatient system of care is both inadequately resourced and provides an inadequate array of services, especially for people outside the public mental health system.
- There is evidence that more comprehensive crisis services can save the system substantial money if resourced to provide a robust diversion role.
- One respondent noted that there is inadequate use of home health, assisted living or nursing home “stepdowns” from psychiatric inpatient units, which may lead to discontinuities in care. (Crisis beds can also serve in this “back-door diversion” role.)
- One respondent suggested a series of “metrics” that could address inadequacies in commercial coverage (and perhaps in the Health Insurance Exchange to be devised under the ACA). These included
 - Rates by which providers accept new outpatient referrals, by provider
 - Rates of outpatients who are unable to make appointments with provider, by provider
 - Average wait time for a new intake appointment, by provider
 - A “one-click” seamless reporting system to the Maryland Insurance Administration when a patient is unable to obtain a provider

Some of this would be accessible directly from claims data, and others could be captured by live patient feedback on the provider site, or on an independent MIA-based website.

- One respondent expressed concerns about the racism and the involuntary treatment process.
- Several respondents suggested that the state needs housing options that are independent of services
- Several respondents spoke movingly about how difficult it has been to access care for their seriously ill family members, noting the following issues
 - Services are often highly disconnected and “discoordinated”
 - There is a huge gap between people who need treatment badly and who can be treated over their own objections (however compromised their mental state)
 - There is a shameful situation in that people with commercial insurance have a harder time accessing care for serious mental illness than those in the public mental health system
 - Delays in care are associated with poorer response to treatment and should be minimized

- Several respondents discussed the need for increased peer-based services, not only in peer-run “wellness” or “drop-in” programs but also within the service delivery system. There has been movement toward a “peer specialist” certification, which will render these services eligible for reimbursement in the public mental health system.
- One respondent pointed out that there may be value in identifying two or three issues in order to make the recommendations more accomplishable, and suggested that there are two overarching issues in this discussion
 - How can we develop a system that provides “treatment on demand” for those seeking care?
 - How can we develop a system that provides care to those who need it but do not want it?

Gayle Jordan-Randolph closed the meeting with a brief wrapup, in which she underscored the following points:

- We need to review standards relating to the emergency petition (EP) process, including the workup in the Emergency Room for patients presenting on an EP
- There needs to be a review of the type of care people receive, including somatic care. This should include a discussion of increased use of in-home supports and services
- The discrepancy in care provided under commercial insurance as compared with the PMHS demands scrutiny. Medical necessity criteria probably are identical, so the issue appears to be related to the authorization process. There is a need to standardize this, which may require some mechanism to develop and analyze data
- Dr. Jordan-Randolph suggested that one mechanism for revising the CRP statute in light of the *Kelly* decision (and, perhaps, involuntary outpatient commitment) would be to focus on the dangerousness aspects of a situation rather than the “need for treatment/lack of insight” aspect of the situation. She further suggested that “we have lost sight of the need to engage people in care.”
- Finally, she suggested that we need to develop a system of care in which people move between levels of care seamlessly and directly.

The meeting ended at 1500.

Minutes prepared by Erik Roskes, with assistance from Erin McMullen and Stacy Reid-Swain.